1921 Oak Tree Road, Suite 103
Edison, NJ 08820
Phone: 732.494.1655
Fax: 732.494.1255
www.laser-spine.com

Patient Name: ______________________

PLEASE COMPLETE THIS QUESTIONNAIRE TO HELP US BETTER UNDERSTAND & ASSIST YOU

Primary Care Physician: ______________________ Phone #: ________________

CURRENT HISTORY:

What is the main reason for your visit today? (Check all that apply)

- ☐ Back Pain ☐ Neck Pain
- ☐ Leg Pain ☐ Arm Pain
- ☐ Other: ________________________________

How and when did your pain begin?

- ☐ On the job ☐ Motor Vehicle Accident (Date of Accident: __________)
- ☐ It comes & goes ☐ I don't know when it began
- ☐ I've had it a long time (about ____ years)

How long has this been a problem?

- ☐ less than 2 months ☐ 2-6 months
- ☐ 6-12 months ☐ greater than 1 year

Describe your injury or onset of problem:

____

____

Have you been treated by any other Physician/Care Giver for this condition? ☐ No ☐ Yes
If yes, please write name of Physician/Care Giver and Specialty:

____

____

____

How does each of the following affect your pain? Please check.

Sitting	☐ Better	☐ Worse	☐ No change
Standing	☐ Better	☐ Worse	☐ No change
Walking	☐ Better	☐ Worse	☐ No change
Lying Down	☐ Better	☐ Worse	☐ No change
Rising from Chair	☐ Better	☐ Worse	☐ No change
Heat	☐ Better	☐ Worse	☐ No change
Cold	☐ Better	☐ Worse	☐ No change
Massage	☐ Better	☐ Worse	☐ No change
Physical Activity	☐ Better	☐ Worse	☐ No change

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How bad is your current pain?

PAIN LEVEL	No Pain	0
	Mild	1-3
	Moderate (distressing pain bearable for some time)	4-6
	Severe (horrible pain bearable for a short time)	7-9
	Excruciating (horrible pain, unbearable for any time)	10

Low Back Pain	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Leg Pain:					
Right	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Left	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Both	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Middle Back Pain	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Neck Pain	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Arm Pain					
Right	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Left	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Both	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Buttock Pain					
Right	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Left	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating
Both	☐ No pain	☐ Mild	☐ Moderate	☐ Severe	☐ Excruciating

Previous Treatments:

Chiropractic Treatment	☐ No	☐ Yes	Date: ________________
Spinal Injections	☐ No	☐ Yes	Date: ________________
Acupuncture	☐ No	☐ Yes	Date: ________________
Psychiatric Therapy	☐ No	☐ Yes	Date: ________________
Physical Therapy	☐ No	☐ Yes	Date: ________________

Previous Tests: (please check all that apply)

☐ X-Ray ☐ MRI ☐ Discography ☐ CAT Scan ☐ CT/Myelogram

☐ Bone Scan ☐ Nerve Test (EMG/NCV)

☐ Other (Please specify) ______________________________

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Do you have the following symptoms?

Weakness

- arms/hands ☐ none ☐ left ☐ right ☐ left & right
- legs/feet ☐ none ☐ left ☐ right ☐ left & right

Numbness (loss of feeling)

- arms/hands ☐ none ☐ left ☐ right ☐ left & right
- legs/feet ☐ none ☐ left ☐ right ☐ left & right

Tingling (falling asleep)

- arms/hands ☐ none ☐ left ☐ right ☐ left & right
- legs/feet ☐ none ☐ left ☐ right ☐ left & right

Is your pain worse at night? ☐ Yes ☐ No

Does your pain awaken you from sleep? ☐ Yes ☐ No

Does coughing affect your pain? ☐ Yes ☐ No

Does your legs tire/hurt if you walk too far? ☐ Yes ☐ No

If yes, please answer the following:

How far can you walk? ☐ less than 1 block ☐ 1-3 blocks ☐ more than 3 blocks

Is this relieved by resting your legs? ☐ Yes ☐ No

Is this relieved by bending forward? ☐ Yes ☐ No

Bladder control (urine): ☐ No problem ☐ Can't empty bladder ☐ Loss of urine (accidents)

Bowel control: ☐ No problem ☐ Constipation ☐ Loss of control (accidents)

Please list all current medications:
(including over-the-counter e.g. Tylenol, Aspirin, herbal and natural supplements)

Medication	Reason Taken	Dosage	Prescribed Doctor

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Are you allergic to any medication? ☐ YES ☐ NO

Please list Medication Allergies:

____

____

Are you allergic to contrast dye or media? ☐ YES ☐ NO

Are you allergic to LATEX? ☐ YES ☐ NO

Previous Medical History:

☐ Heart Attack ☐ Angina ☐ High Blood Pressure ☐ Stroke ☐ Stomach Ulcer

☐ Duodenal Problems ☐ Diabetes ☐ Kidney Stoners ☐ Gout ☐ Hepatitis Cirrhosis

☐ Depression ☐ Anxiety ☐ Degenerative Arthritis ☐ Asthma ☐ Bleeding Tendency

☐ Rheumatoid Arthritis ☐ Anemia ☐ Emphysema/Bronchitis ☐ Menstrual Problems

☐ Cancer: type ______________________

☐ Other: __________________________

List any previous surgeries and dates:

Type of Surgery	Surgery Date

Social History

Do you smoke? ☐ Yes. ___ packs per day for ____ years ☐ No ☐ Quit

Do you drink alcoholic beverages? ☐ Yes ☐ No ☐ Socially

Do you have a drug history? ☐ No ☐ Yes. If so, please describe _______________

Highest Educational Attainment: ☐ Grammar ☐ High School ☐ College ☐ Post-graduate

Is there any litigation pending? ☐ Lawsuit ☐ Workers Comp

☐ Disability Claim ☐ S.S. Claim

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Review of Systems

Do you have any of the following?

1. Recent weight loss of more than 10 pounds ☐ Yes ☐ No
2. Recent weight gain of more than 10 pounds ☐ Yes ☐ No
3. Seen primary care physician in last year ☐ Yes ☐ No
4. Fever ☐ Yes ☐ No
5. Chills ☐ Yes ☐ No
6. Night Sweats ☐ Yes ☐ No

Cardiac:

Chest Pain ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No

Respiratory System:

Wheezing ☐ Yes ☐ No
Pneumonia ☐ Yes ☐ No
Chronic Cough ☐ Yes ☐ No

Gastrointestinal:

Abdominal pain ☐ Yes ☐ No
Nausea ☐ Yes ☐ No
Vomiting ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Liver Problems ☐ Yes ☐ No

Skin:

Open sores ☐ Yes ☐ No
New moles ☐ Yes ☐ No
Poor healing ☐ Yes ☐ No
Skin infection ☐ Yes ☐ No

Hematologic/Oncologic:

Easy bruising ☐ Yes ☐ No
Blood thinning medications ☐ Yes ☐ No
Blood transfusions ☐ Yes ☐ No
Organ transplant ☐ Yes ☐ No

Endocrine:

Thyroid problems ☐ Yes ☐ No

Bones/Joints:

Shoulder pain ☐ Yes ☐ No
Wrist and hand pain ☐ Yes ☐ No
Hip pain ☐ Yes ☐ No
Knee pain ☐ Yes ☐ No
Lupus ☐ Yes ☐ No
Muscle weakness ☐ Yes ☐ No
Fibromyalgia ☐ Yes ☐ No

Genitourinary:

Abnormal kidney function ☐ Yes ☐ No
Pain during urination ☐ Yes ☐ No
Frequent urinary infections ☐ Yes ☐ No

Nervous System:

Headache ☐ Yes ☐ No
Tremors ☐ Yes ☐ No
Poor speech ☐ Yes ☐ No
Changes in Vision ☐ Yes ☐ No

Mental Health:

Sleep disturbance ☐ Yes ☐ No
Feeling of hoplessness ☐ Yes ☐ No